

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-025834

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 247

FILED AUG 6 1962

1. PLACE OF DEATH a. COUNTY <u>Adair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville Mo</u>		Length of stay in 1b <u>1 mo</u>	c. CITY OR TOWN <u>Brashear Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stickler Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R 7 D</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH NANCY BRAWNER</u>			4. DATE OF DEATH Month Day Year <u>July 31- 62</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1872</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days <u>4 4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L</u>	11. BIRTHPLACE (City and state or country) <u>Adair Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William Floyd</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Willis</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas Brawner - dec'd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>L</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Maude Landwig Brashear Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>					<u>Immediately</u>
DUE TO (b) <u>Hypertension</u>					<u>4-5 yrs.</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 30, 1962</u> to <u>July 31, 1962</u> and last saw her ^{her} _{him} alive on <u>July 31, 1962</u> Death occurred at <u>9:10 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R O Stickler MD</u> (Degree or title)			22b. ADDRESS <u>107 E. Harrison, Kirksville, Mo.</u>		22c. DATE SIGNED <u>8/1/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 2-62</u>	23b. DATE <u>Aug 2-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Kirksville Mo</u>	
24. FUNERAL HOME <u>Dee Riley Funeral Home, Inc.</u> 415 North Franklin Kirksville, Missouri		25. DATE RECD. BY LOCAL REG. <u>Aug. 1, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>	
(Licensed Embalmer's Statement on Reverse Side)					

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MPT. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
<u>10017</u>
<u>20010</u>
<u>3</u>
<u>4 1</u>
<u>5 2</u>
<u>6</u>
<u>7 0</u>
<u>8 0</u>
<u>9331X</u>
<u>10</u>
<u>11</u>
<u>12 4-0</u>
<u>13 1-0</u>

No permit issued

R. O. STICKLER, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm A. Jackson

Licensed Embalmer No. 73954

P. O. Address Kipsville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.